Senate

General Assembly **File No. 508**

February Session, 2016 Substitute Senate Bill No. 289

Senate, April 6, 2016

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (e) of section 38a-1084a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) (1) On and after **[**January 1, 2017**]** sixty days after the report described in subsection (c) of this section is initially made available to the public on the Insurance Department's and Department of Public Health's Internet web sites, each hospital shall, at the time of scheduling a diagnosis or procedure for nonemergency care that is included in the report submitted to the exchange by the Insurance Commissioner and the Commissioner of Public Health pursuant to subsection (c) of this section, notify the patient of the patient's right to make a request for cost and quality information. Upon the request of a patient for a diagnosis or procedure included in such report, the hospital shall, not later than three business days after scheduling such diagnosis or procedure, provide written notice, electronically or by

mail, to the patient who is the subject of the diagnosis or procedure concerning: (A) If the patient is uninsured, the amount to be charged for the diagnosis or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the admission or procedure, including the amount of any facility fee; (B) the closest corresponding Medicare reimbursement amount; (C) if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs; (D) The Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and (E) the Internet web site addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

(2) If the patient is insured and the hospital is out-of-network under the patient's health insurance policy, such written notice shall include a statement that the diagnosis or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply.

Sec. 2. Section 38a-477e of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On and after July 1, 2016, each health carrier shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the exchange pursuant to section 38a-1084a, as amended by this act, for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible

for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) a list of in-network health care providers, (iv) whether a health care provider is accepting new patients, and (v) languages spoken by health care providers; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services.

(b) A health carrier shall advise the consumer when providing the information on out-of-pocket costs that the amounts are estimates and that the consumer's actual cost may vary due to health care provider contractual changes, the need for unforeseen services that arise out of the proposed admission or procedure or other circumstances.

(c) The provisions of this section shall not apply to a health carrier with less than forty thousand covered lives for the health carrier in the state. If in any year, a health carrier exceeds forty thousand covered lives for the health carrier in the state, the provisions of this section shall begin to apply on January first in the following year.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-1084a(e)
Sec. 2	*from passage*	38a-477e

Statement of Legislative Commissioners:
In two places in Section 2(c), "company" was changed to "health carrier" for internal consistency.

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill, which changes the starting date of a notification requirement and excludes certain health carriers from website and toll-free telephone number requirements, does not result in a fiscal impact to the state or municipalities.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sSB 289

AN ACT CONCERNING HEALTH CARE SERVICES.

SUMMARY:

This bill makes certain changes to requirements enacted in PA 15-146.

It (1) changes the starting date for a requirement that hospitals notify patients scheduling a common nonemergency diagnosis or procedure of their right to request related cost and quality information and (2) makes a minor change to the information hospitals must report.

Starting this July 1, PA 15-146 requires each health carrier to maintain a website and toll-free telephone number where consumers may obtain information on in- and out-of-network costs and related information (see BACKGROUND). The bill exempts from this requirement carriers with fewer than 40,000 covered lives in Connecticut. If a carrier exceeds 40,000 covered lives in a given year, the carrier becomes subject to the requirement starting the following January 1.

EFFECTIVE DATE: Upon passage

HOSPITAL INFORMATION ON NONEMERGENCY CARE

Under current law, beginning in 2017, hospitals must notify patients scheduling common nonemergency diagnoses or procedures of their right to request related cost and quality information. This requirement applies to diagnoses and procedures included in reports from the public health and insurance commissioners (see BACKGROUND). The bill changes the starting date of this requirement, from January 1, 2017 to 60 days after the commissioners make available their first such

report.

By law, if a patient requests a diagnosis or procedure listed in the report, the hospital must provide certain information to the patient within three business days after scheduling the diagnosis or procedure. Under current law, the required information includes the Medicare reimbursement amount. The bill specifies that this refers to the closest corresponding Medicare reimbursement amount.

BACKGROUND

Carrier Websites and Toll-Free Telephone Numbers

Under PA 15-146, starting July 1, 2016, health carriers must maintain websites and toll-free telephone numbers allowing consumers to request and obtain information on in-network and out-of-network costs for health care procedures, services, and inpatient admissions. The in-network information must include:

1. the allowed amount for at least the admissions and procedures reported to the Connecticut Health Insurance Exchange under the act, for each provider in the state;

2. the estimated out-of-pocket costs that the consumer would be responsible for paying for these admissions or procedures that are medically necessary; and

3. data or other information on (a) quality measures for the provider; (b) patient satisfaction, if available; (c) a list of in-network providers; (d) whether a provider is accepting new patients; and (e) languages spoken by providers.

When providing information on out-of-pocket costs, carriers must advise consumers that the amounts are estimates and that the actual cost may vary due to (1) provider contractual changes, (2) the need for unforeseen services, or (3) other circumstances.

Public Health and Insurance Commissioners' Reports

Under PA 15-146, starting by July 1, 2016, the commissioners must

annually report the following information on in-state health procedures, to the extent it is available:

1. the 50 most frequent inpatient primary diagnoses and procedures,
2. the 50 most frequent outpatient procedures,
3. the 25 most frequent surgical procedures, and
4. the 25 most frequent imaging procedures.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 28 Nay 0 (03/21/2016)